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ABSTRACT OF THESIS

ANALYSIS OF EMERGENCY DEPARTMENT NURSE ATTITUDES TOWARD CARING FOR ETHNICALLY DIVERSE PATIENTS

Nurses in the Emergency Department (ED) care for patients from different races, cultures, and ethnic backgrounds. Because of this, it is imperative that nurses appreciate and respect ethnic views of health and illness as they care for culturally diverse individuals. The purpose of this study was to assess civilian and military ED nurse attitudes toward caring for ethnically diverse patients. This descriptive study was conducted at three south central U.S. hospitals. The sample consisted of Registered Nurses (N=41) working in the ED who completed the investigator designed Cultural Care Questionnaire (CCQ), a measure of ED nurse attitudes toward caring for a culturally diverse population. No significant differences were found between CCQ responses and amount of minority exposure, nursing education, ethnic background, or cultural education of the sample. Significant differences in scores were found between gender, and between civilian and military nurses. Males received lower scores than females, and military nurses scored lower than civilian nurses, implying less positive attitudes. An age difference between civilian and military nurses was also found. Results suggest that cultural exposure is not significantly related to ED nurse attitudes. Relationships between gender, age, and workplace need further investigation before conclusions may be drawn.

Catherine Medland
12 December 1997

ANALYSIS OF
EMERGENCY NURSE ATTITUDES
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THESIS

Catherine Ann Medland

The Graduate School
University of Kentucky
1997

ANALYSIS OF
EMERGENCY DEPARTMENT NURSE ATTITUDES
TOWARD CARING FOR ETHNICALLY DIVERSE PATIENTS

THESIS

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Nursing
at the University of Kentucky

By

Catherine Ann Medland

Lexington, Kentucky

Director: Dr. Dorothy Brockopp, Professor of Nursing

Lexington, Kentucky

1997

MASTER'S THESIS RELEASE

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This thesis is dedicated to

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* my parents, Phil and Dorothy Wheeler, whose support and love taught me that anything is possible;
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Introduction

Nurses regularly care for patients from different races, cultures, and ethnic backgrounds. The Emergency Department (ED) is no exception, and often the ED nurse is the first health care contact for minorities and new immigrants (ENA, 1995). Because ED nurses care for people from a variety of cultural backgrounds, it is imperative that they appreciate and understand ethnically relevant views of health and illness as they care for culturally diverse individuals.

The author, a military nurse, was interested in studying attitudes of ED nurses in both military and civilian settings after living as a minority in a foreign country and finding how it changed her cultural perspective. The author wanted to research whether nurse attitudes were more positive or negative among those who had lived as a minority as compared with those who had not.

Purpose of the Study

The purpose of this study was to survey civilian and military ED nurses to assess current attitudes toward caring for patients of diverse ethnic backgrounds.

Research Question

What are the attitudes of civilian and military ED nurses toward caring for patients from diverse ethnic backgrounds?

Significance of the Study

This study examined and compared civilian and military nurse attitudes to determine if cultural exposure was related to nurse attitudes toward caring for ethnically diverse patients. If an association was found between ED nurse attitudes and cultural exposure, it was felt that this study might prove pertinent to military assignment protocol as well as nursing education and nursing cultural exchange programs.

For example, if increased cultural exposure was found to correspond with positive attitudes, this would provide research data to support ongoing cultural education and exchange program efforts. Perhaps the military would encourage nurses to take overseas assignments early in their careers, to promote job satisfaction and improve nursing attitudes.

Nurses are the largest group of professional health care providers, which provides them a unique opportunity to influence many patients in the health care arena. ED nurses have the potential to play key roles in preventing cultural problems and improving health care opportunities, based partly upon their attitudes toward ethnically diverse patients. Nurses can educate patients regarding access to the health care system, assist them in understanding procedures and the rationale for them, and help them to feel

accepted and worthy of care, which is part of the professional role in nursing.

Definitions

Attitude is a "manner, disposition, or feeling with regard to a person or thing" (Random House Webster's Dictionary, 1993, p. 41). Attitudes are important because they shape how one observes and interacts with others.

Bias means "a particular tendency or inclination; prejudice" (Random House Webster's Dictionary, 1993, p. 64). A bias can be positive or negative, depending on the circumstances.

Cultural diversity refers to differences between people based on a shared ideology and valued set of beliefs, norms, customs, and meanings evidenced in a way of life (ANA, 1991). It is the differences among various groups of people (Talabere, 1996). Cultural diversity is not limited to traditionally defined minority groups, and can include groups of people with different lifestyles from the dominant population due to religious beliefs, employment status, sexual orientation, and so forth (Princeton, 1993).

A culturally or ethnically diverse patient is one from any cultural and/or ethnic background different from that of the caregiver (for the purposes of this study).

Ethnicity is frequently and perhaps erroneously used to mean race, but it includes much more than a biological identity. The term refers to groups whose members share a

common social and cultural heritage passed on to each successive generation. The most important characteristic of ethnicity is that members of an ethnic group feel a sense of identity (Giger & Davidhizar, 1995).

Ethnocentrism is defined as the belief that one's own culture is superior to others. This belief is common in cultural groups, as all groups regard their own culture as not only the best, but also the correct, moral, and only way of life (ANA, 1991). This pervasive, often unconscious belief is imposed on every aspect of day-to-day interaction and practices including health care. It is this attitude which has great potential to create problems between nurses and clients of diverse culture groups.

In this study, minority is defined as a particular racial, religious, or occupational group that constitutes less than a numerical majority of the population. Although many different definitions exist, this study's use of the word does not imply lack of power, assumed inferior traits, or undesirable characteristics, as do some definitions (Giger & Davidhizar, 1995).

Chapter Two

Review of the Literature

Providing culturally appropriate care in the ED is a complex and difficult task for many nurses. As patients are often critically injured, time is of utmost importance in ensuring appropriate medical treatment is provided. Obtaining accurate information about past medical history and recent injuries can prove crucial to the patient's recovery. If language or cultural barriers are present, these can interfere with providing lifesaving, as well as culturally congruent, care.

Bias

American society is rapidly increasing in cultural diversity. Currently the U.S. population is comprised of 73% White, 12% Black, 11% Hispanic, 3% Asian and Pacific Islander, and 1% American Indian, Eskimo, and Aleutian (U.S. Bureau of the Census, 1997). By the year 2000, more than one quarter of the U.S. population will consist of ethnic minorities, and by 2080, these minorities will, in fact, be the majority (Andrews, 1992).

Nurse attitudes with a tendency toward cultural bias may have negative implications and present barriers to effective client care which can exacerbate stress and trauma to patients (Parfitt, 1988). Therefore nurses must be aware of and constantly attempt to decrease their own potential bias

and work to understand cultural differences to improve health care.

Nurses can create positive or negative situations for minorities seeking health care based on the client's language and/or behavior. If communication is a problem, non-English speaking clients may experience delays or be ignored, causing a negative patient attitude. The nurse, in turn, may form a judgmental attitude because a patient refused to cooperate with treatment due to a perceived bias from the nurse (Guruge & Donner, 1996).

Although the health care system has recently increased efforts to meet diverse cultural needs, high morbidity and mortality rates persist among ethnic groups, and are thought to be a consequence of apathy from health care professionals toward ethnic clients (Louie, 1985). Treatment modalities should acknowledge and reflect cultural differences while remaining accessible to all.

One study by Branch (as quoted by Louie, 1985) revealed that recent standards of care were found to be appropriate for middle class Caucasians only, in part due to disadvantages such as language difficulties, poverty, lower standards of living, discrimination, and lack of access to health care. Culturally diverse patients and those from low socioeconomic backgrounds received less than optimal care as a result, which is unacceptable since it excludes those who may need care the most.

Cultural Traditions

In a multiethnic society, optimal patient care can only be accomplished if health care providers understand rationale behind cultural traditions and healing methods. For example, providing culturally congruent care necessitates that caregivers understand such things as the reason Asian patients rarely ask for pain medication whereas patients from Mediterranean countries seem to need it for the slightest discomfort, why Middle Eastern men will not allow male physicians to examine their women, and why coin-rubbing is an Asian form of medical treatment, not a method of child abuse (Galanti, 1991).

Health care providers should make every effort to incorporate traditional cultural beliefs of the various minority groups into planned treatment protocols (AAN, 1992). Some nurses minimize the significance of traditional health beliefs and practices and have negative attitudes toward patients who are culturally different (Bonaparte, 1979). This is often unnecessary, because something as simple as allowing a patient to wear religious articles can exert real or perceived beneficial effects. Traditional articles can often remain with the patient, providing peace of mind without hindering health care interventions.

Nursing

The International Council for Nurses' Code for Nurses states that "The need for nursing is universal. Inherent in

nursing is respect for life, dignity and rights of man. It is unrestricted by considerations of nationality, race, creed, color, age, sex, politics or social status" (as quoted by Abdullah, 1995, p. 716).

Although both patient and nurse beliefs about health care are governed by cultural rules, nurses do not always explore patient beliefs about health, disease, or illness behaviors, nor do they routinely clarify their own beliefs with the patient. Often patients are labeled noncompliant when nurses do not get the outcomes or behaviors they desire from them (Charonko, 1992). This type of behavior can occur because families who are ethnically and culturally different from their health care providers may feel looked down upon or disrespected in the clinical interaction and may feel the provider is not truly interested in their well-being (Brookins, 1993).

According to the American Nurses Association (ANA, 1991), knowledge about cultures and the impact of culturally based behavior on health care interactions is essential at all levels of nursing practice, including advanced as well as basic, and should influence nursing roles in the clinical setting, educational, research, and administrative areas. By serving as client advocates and providing effective cultural assessments, nursing care to diverse ethnic groups can be greatly improved.

Access to care

Even with recent advances in cultural care, unethical practices such as sexism and racism remain a problem in the U.S. health care system (Meleis, 1995). Although the economy of the U.S. has improved in the past few years, unemployment, decreasing opportunities, and limited options for minorities and immigrants contribute to limited health care access.

The ANA recommends improving access to care by encouraging nurses to provide culturally relevant, responsive services to their patients (1991). The ANA's Position Statement on Cultural Diversity in Nursing Practice stresses that nurses should recognize cultural diversity, integrate cultural knowledge, and use this knowledge to develop and implement culturally sensitive nursing care. This would enable nurses to be more effective in initiating nursing assessments and serving as client advocates.

Lack of Cultural Understanding

Often the health needs of patients with diverse cultural backgrounds are not completely met due to problems that are only partially recognized by health care providers (Murphy & Macleod, 1993). Most of these problems arise from the lack of knowledge, understanding and awareness on the part of the nurses and other health care professionals on issues relating to the cultural background of their clients.

Too often care provided by a nurse with a cultural background different than the patient tends to reflect the nurse's view, which may have a negative impact on nursing interventions (Abdullah, 1995). Often this is subconscious, but still results in biased nursing care.

For example, a retrospective study of 180 patients, 40 of whom were ethnic minorities, showed that white patients in the sample received significantly more total postoperative narcotic analgesics than ethnic minority patients (McDonald, 1994). The differences in narcotic analgesic administration among ethnic groups lends support to the hypothesis that irrelevant cues, such as giving low credibility to minority patients' expressions of pain, and misunderstandings regarding pain level due to language barriers and non-verbal behaviors, are sometimes inadvertently used by nurses in making inappropriate medication decisions. This example demonstrates that nurse attitudes towards ethnically diverse clients can have a strong impact on patient care, as well as on the patient's perception of care.

Identifying client and nurse beliefs and expectations are important when providing culturally congruent care. Clients and nurses may not always have the same health goals. Cultural backgrounds play a large role in determining our goals, and in assessing how they can be achieved. If nurses are to help clients achieve their goals

and reach the maximal level of wellness, nursing care must include cultural assessments of both the patient and the nurse (Charonko, 1992).

Transcultural Nursing

Madeleine Leininger (1991), in an effort to improve health care to ethnically diverse clients, stresses the importance of considering cultural needs among patients. The founder of transcultural nursing, Leininger emphasizes that people from cultures worldwide have a right to have their cultural care values known, respected and appropriately used in nursing and other health care services (1991).

Leininger describes transcultural nursing as a blend of nursing and anthropology which attempts to help nurses understand the beliefs, values, and practices of different cultures to provide culturally sensitive care. She argues that cultural factors are an integral part of health care, essential to providing effective, satisfying, meaningful and beneficial health care to clients. Without the inclusion of cultural factors in health services, health personnel can only provide partial and therefore incomplete health services (Leininger, 1995).

The mixing of cultures, or multiculturalism, is a fact of life. Depending upon one's conceptual system, this fact may be viewed either as a problem in need of a solution or a gift to enjoy (Speight, Myers, Cox, & Highlen, 1991). To

truly value and appreciate the diversity of human expression and experience, nurses should emphasize the similarities while appreciating and caring for cultural differences. Recognizing differences is not discriminatory, but recognizing a difference and either ignoring it or treating that person less favorably because of one's attitude, is unethical and unprofessional (Williams, 1996), and is a problem that nurses must seek to eliminate.

Caring

Caring is exemplified when one has a commitment to assist another person when they are incapable of carrying out specific functions associated with their physical, psychological and psychosocial needs (Abdullah, 1995). Care has long been regarded as the foundation of nursing practice (Giger & Davidhizar, 1995). Professional caring embodies the cognitive and deliberate goals, processes, and acts of professionals in providing assistance to others, expressing attitudes and actions of concern for them to support their well-being, alleviating undue discomforts, and meeting obvious or anticipated needs (Leininger, 1984).

Nurse attitudes directly affect caring by their positive or negative impact on the patient. In her study analyzing open and closed mindedness as it relates to nurse attitudes, Bonaparte (1977) found that younger nurses tended to be more ego defensive than older nurses, and open mindedness appeared to increase with experience. She also found that

close-minded nurses sometimes unconsciously avoid culturally different clients when their health beliefs cause conflict with the nurse's "rational" scientific approach. This could be anxiety producing and had the potential to threaten the nurse's professional image.

A later study by Bernal & Froman (1987) contradicted prior research by finding no clear profile distinguishing the transculturally efficacious nurse from less confident colleagues. Education, age, years in nursing, and practice specialty offered no significant predictive worth in regards to nurse attitudes when caring for ethnically diverse patients.

Ethnocentrism

The view that one's own culture is superior to all others, ethnocentrism, is problematic with health care providers today. Lack of cultural sensitivity by providers has been found to create misunderstandings and contribute to negative attitudes among culturally diverse individuals (Andrews, 1992). This insensitivity is costly and alienates the very people whom nurses purport to help.

A study by Greipp (1995) found that ethnocentrism on the part of health care providers has led to misdiagnosis, undertreatment and mistreatment of culturally diverse individuals worldwide. Actual examples include the institutionalization of culturally diverse patients incorrectly diagnosed with schizophrenia, failure to provide

adequate pain relief for patients due to lack of understanding about their cultural expression of discomfort, and the arrest of parents for child abuse because culturally based childrearing practices were poorly understood by Anglo nurses (Andrews, 1992).

Non-ethnocentric nurses have been found to be more alert to cultural cues needed to establish a cooperative treatment relationship among ethnic clients than nurses possessing ethnocentric traits (Ruiz, 1981). Ruiz suggests providing exposure to cultural differences by sharing common situations with different people and having the opportunity to learn how each approaches life with its problems, as a way of expanding nurse viewpoints and improving their attitudes.

Minorities

All patients, regardless of their ethnic background, deserve to be treated fairly and without bias when seeking health care. However, minority clients often encounter the most difficulties within the U.S. health care system (AAN, 1992). There are many possible influences for this, such as bias, ethnocentrism, negative attitudes, and lack of cultural understanding among health care providers.

The U.S. has a highly diverse population, and a major problem for newcomers is understanding the way American health care is provided. This can be vastly different from the homeland of many immigrants, where socialized health

care may be the norm. Terms such as HMOs (Health Maintenance Organizations), primary care, and managed care are as foreign to them as American English (K. Qualls, personal communication, July 10, 1997).

A person requiring health care may come to the ED because they do not know how to otherwise access care in the U.S. The ED nurse has the potential and obligation to assist, educate, and care for these patients and to help make their ED experience a positive one.

Attitude

In the nurse-patient relationship, attitudes can influence every action and interaction the patient has with the health care system. For example, nurses working in large urban hospitals can be predisposed to negative attitudes and bias related to violence, substance abuse, socioeconomic status and/or ethnic groups who frequent the ED. This can lead to the unethical practice of judging patients (Greipp, 1995).

One of nursing's prime health care goals is to provide improved options and expanded access to care for patients, including disenfranchised, stigmatized, and discriminated-against populations (AAN, 1992). In a democratic society, discrimination for any reason is unacceptable and patients from all cultures deserve the highest standard of health care. Providing quality individualized patient care cannot be achieved without considering the context of the client as

a whole person and by including factors associated with the personal being, such as culture, beliefs, and tradition, into their care (Abdullah, 1995).

Understanding attitudes of both nurses and patients is the first step to designing interventions that will be culturally congruent and acceptable to patients and caregivers alike. A 1996 study found that attitudes are affected by cross-cultural experiences and personal attributes, such as flexibility, empathy, and language facility (Lipson, Dibble, & Minarik).

The American Academy of Nursing (AAN) Expert Panel on Culturally Competent Nursing Care stresses that it is each nurse's professional duty to provide the best cultural care possible for all populations (AAN, 1992). To improve attitudes and provide culturally congruent care, the panel recommends that nurses develop an appreciation for cultural diversity, adopt a willingness to confront their own ethnocentric and racist beliefs, and begin implementing and evaluating health care services to culturally diverse populations (Alpers & Zoucha, 1996).

Cultural Education

Many nurses today have not received specific education in caring for patients from diverse cultures. Only forty percent of baccalaureate nursing students and approximately seventeen percent of master's prepared nurses have had substantial courses in transcultural nursing (Leininger,

1995). Substantial courses infers the completion of seminars, field work, and immersion in transcultural nursing with mentorship, resulting in certification in transcultural nursing (M. Leininger, personal communication, July 8, 1997). Finding faculty with this type of education is also difficult, as Leininger reports that fewer than twenty percent of faculty and less than two percent of doctorally prepared nurses in the U.S. have had substantial transcultural education (1995).

Caring for ethnically diverse patients without receiving transcultural training can cause stress among nurses. One study by Murphy & Clark (1993) revealed comparable experiences, problems, and challenges among nurses who cared for patients whose ethnic background differed from their own. The most troublesome areas were poor communication and lack of knowledge about cultural differences. These researchers found that the inability to provide holistic care and difficulties in developing therapeutic relationships with ethnically diverse patients contributed to substantial amounts of frustration and stress. Many nurses expressed that the inability to give the standard of care that was both desired and deserved was a major contributor to stress (1993).

Conflicting results have been found in the literature in regards to how nurses feel about caring for patients after receiving specialized cultural training. Leininger

claims that problems such as noncompliance, frustration and anger toward culturally different individuals are often due, in part, to nurses who label, avoid, or talk down to patients when they do not understand their behavior and needs (1995). After receiving transcultural training, Leininger states that many nurses report decreases in frustration, anger, and helplessness, after better understanding patient beliefs, behaviors, and cultural practices.

One study by Alpers & Zoucha (1996) found that nursing students who received some cultural course content felt less competent and confident in providing culturally sensitive care than those who received no cultural course content. After further analysis, the authors suggested that the competent and confident group actually held a true lack of cultural knowledge, which suggested the initial results could have been reflective of an "arrogant ignorance" rather than true knowledge.

Cultural exposure

One of the few studies which analyzed the influence of exposure to diverse cultural backgrounds among nursing personnel found that nursing student participation in an international study program had a positive influence on their cognitive development (Zorn, Ponick, & Peck, 1995). These results supported the hypothesis that any situation or experience that is different from an individual's current

reasoning structure may serve to challenge established views and stimulate cognitive change.

Military nursing

There are many differences between military and civilian nursing. One that might prove significant to this study is that military nurses are salaried, meaning they receive the same amount of pay each month. Pay is based upon rank and time in service, regardless of how many hours worked per week, which could possibly influences attitudes.

Another difference is that Emergency Departments in the military often appear to be extensions of family practice clinics. During weekends, holidays, and after duty hours, the ED may see more non-acute than seriously ill or injured patients. This factor could influence attitudes either negatively or positively, depending upon the patient acuity desired by nurses.

The Defense Technical Information Center (DTIC) in Fort Belvoir, Virginia, contains documentation of nursing research done by nurses from all branches of the military. According to Judy Szcur (personal communication, October 23, 1997), no prior studies have been done among nurses and ethnic patients. Szcur stated that some research regarding minorities in the military has been completed, but none focusing specifically on nurse attitudes toward ethnically diverse patients.

Previous Study

A small pilot study was recently conducted by the researcher in a south central university medical center ED to examine the importance nurses ascribe to obtaining cultural information from patients during initial assessment or subsequent treatment in the ED. Of the nurses surveyed (N=10), 7 reported having seen at least one patient within the past month for whom obtaining cultural information was "vital to their care" (Medland, 1997).

Numerous examples were cited, which illustrate the importance of meeting patients' cultural needs (Table 1). These experiences show that cultural issues occur frequently, and they help exemplify that nursing responses can directly affect the perceived quality of care given to ethnically diverse patients.

Theoretical Framework

The theoretical framework chosen for this research was developed by Linda Rooda, and is based on King's Theory of Goal Attainment (Rooda, 1992). The main propositions of King's Theory of Goal Attainment can be summarized as follows:

1. If perceptual accuracy is present in the nurse-patient interaction, then transactions will occur.
2. If transactions occur in the nurse-patient interaction, goal attainment will improve.
3. Goal attainment leads to satisfaction.

Table 1

Actual Scenarios: Important Cultural Needs in the ED

* A patient who denied a blood transfusion due to religious convictions.
* A family requested to use a prayer cloth as part of a healing ritual.
* Language barriers which proved problematic for discussing care options.
* A patient's husband was offended and angry when a pelvic exam was done on his wife without his presence.
* A husband requested unique post-mortem specifications for his wife's body for religious purposes.
* A patient veiled in a sari requested a private room and female resident for cultural reasons.

(Medland, 1997)

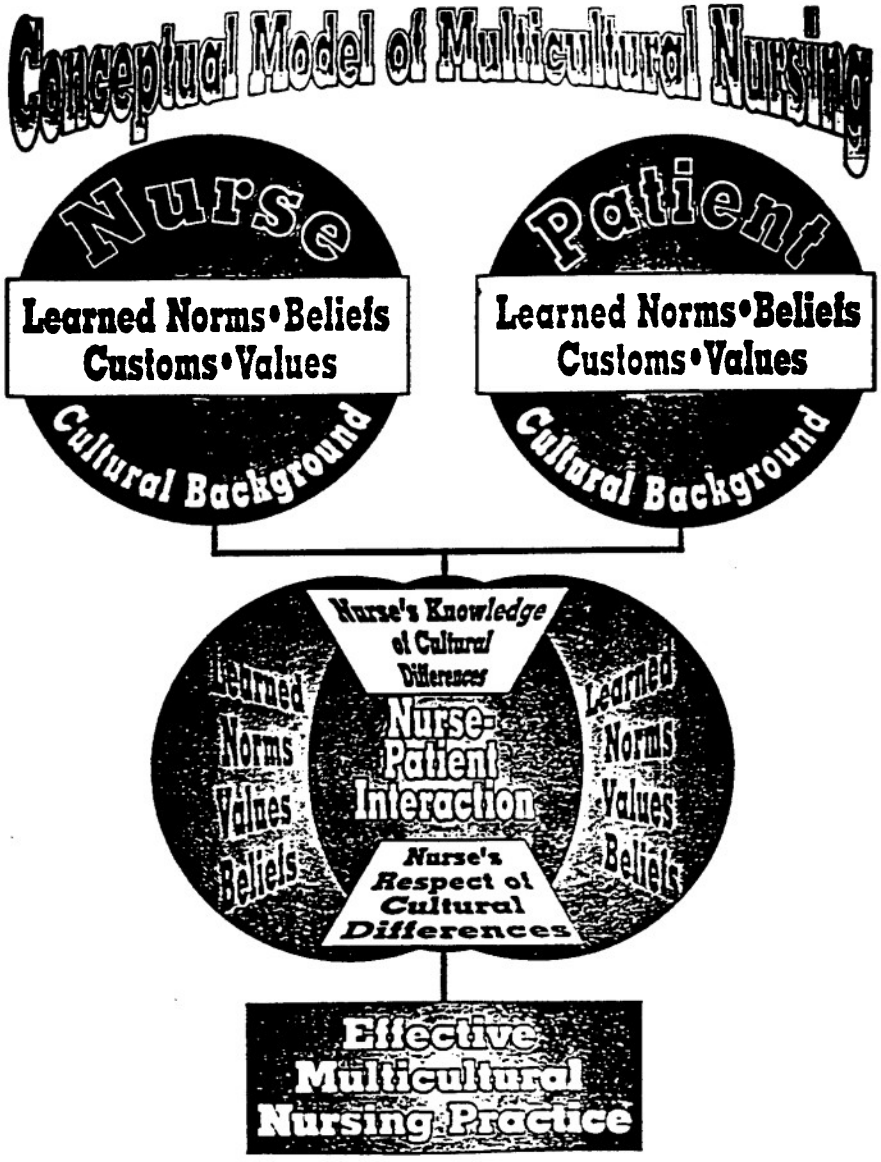
4. If goals are accomplished, effective nursing care results (King, 1981).

In this conceptual model, both the nurse and patient bring their individual cultural backgrounds to the nurse-patient relationship. Those backgrounds are composed of learned norms, beliefs, customs, and values. For nurses to provide culturally sensitive care, they must not only be cognizant of those differences but demonstrate respect for cultures that differ from their own (Rooda, 1992).

Rooda's (1992) Conceptual Model of Multicultural Nursing (Figure 1) demonstrates that in the nurse-patient relationship, the nurse's knowledge of and respect for the patient's cultural background results in perceptual accuracy. This accuracy, in turn, leads to transactions, goal attainment and effective multicultural nursing practice (Rooda, 1992).

Figure 1

Conceptual Model of Multicultural Nursing



Note. From "The development of a conceptual model for multicultural nursing," by L.A. Rooda, 1992, Journal of Holistic Nursing, 10, p. 344.

Chapter Three

Methods

A descriptive design was selected to study military and civilian ED nurse attitudes toward caring for ethnically diverse patients, using the Cultural Care Questionnaire (CCQ).

Sample

The convenience sample for this study was comprised of 41 Registered Nurses (RNs) working in the ED at one of three facilities in the south central U.S. Facilities included a university level 1 trauma center, a Veteran's Administration government hospital, and a military medical center. ED nurses were separated into categories of civilian or military.

Subjects ranged from 24 to 49 years of age, and reported ED experience ranging from 3 months to over 20 years. All RNs who participated, regardless of age, gender, ethnic background, job title, or educational preparation, were eligible to participate so long as their duties were specific to ED nursing. This sample included staff nurses, managers, and clinical nurse specialists. Part-time nurses who specifically worked the ED were also included in this study.

Float nurses who worked in areas other than the ED were not eligible to participate because of their potential to bring experiences and influences from other areas into the study. Civilian flight nurses were also excluded because they have different constraints than ED nurses, such as caring for patients who are often more acutely ill than some in the ED setting. They also usually care for only one patient at a time, and nurse attitudes are not a priority in critical situations flight nurses frequently experience.

Protection of Subjects

Institutional Review Board (IRB) approval of this study was obtained from each institution in which data was to be collected prior to questionnaire distribution. Approval by the IRB ensured exposure to the least amount of risk possible for study participants (Appendix A).

Respondents were informed that participation in this study was strictly voluntary, and that they were free to withdraw from the study at any time. It was stressed to respondents that they should not write their names on the questionnaire in an effort to maintain anonymity and confidentiality. Informed consent was implied by questionnaire completion.

The research purposes were explained by the investigator, and participants were assured that the

questionnaires would not be used for purposes other than this study. No discomfort, fatigue, or other problems were reported by subjects during or after completion of the questionnaire.

Measures

Instrument

The Cultural Care Questionnaire was designed by the author to measure attitudes of ED nurses toward caring for patients of diverse ethnic backgrounds, an aspect that had not been specifically addressed in prior studies. The instrument consists of an explanatory cover sheet and two sections (Appendix B).

Section I of the instrument contains 10 demographic questions. In Section II, a five-point Likert Scale with responses ranging from Strongly Disagree (1) to Strongly Agree (5) is used to assess attitudes regarding caring for ethnically diverse patients. This section consists of 9 questions.

Responses to questions 1-9 in Section II were summarized with a possible minimum score of 9 and a maximum score of 45. The higher the score, the more positive the attitudes presumably were, and lower scores were thought to represent more negative attitudes. Items 1, 4, and 6 were negatively worded and required reverse coding for analysis.

The rationale for utilizing a questionnaire was to encourage respondents to answer questions more honestly than they might have with personal interviews. Surveys are excellent tools for measuring attitudes because they provide a means of determining prevailing attitude trends (Rooda, 1993). Rooda also notes that a self-administered questionnaire is appropriate when questions are highly personal and sensitive, as with this study.

Reliability

Coefficient alpha was used to assess reliability of the CCQ since all items were developed with the intent to measure attitudes toward a single concept, caring for ethnically diverse groups. An alpha of .70 was targeted since this is acceptable for a newly developed and untested tool (Nunnally & Bernstein, 1994).

Validity

To measure content validity, the instrument was given to five experts, who specialized in ED nursing, transcultural nursing, and/or research. They evaluated such areas as format, content, wording, and flow of the instrument. The researcher implemented most recommended changes into the instrument prior to distributing the questionnaire to the sample. Some were excluded because the suggestions were not pertinent to this sample.

Other Instruments

Instruments from prior research were not appropriate for this study because those available measured phenomena related to, but distinctly different from, the researcher's area of interest among attitudes. Bonaparte's Cultural Attitude Scale (1979) measured only attitudes toward four minority groups; Bernal & Freeman's Self Efficacy Scale measured cultural self-efficacy among community health nurses (1987); the Multicultural Awareness-Knowledge-Skills Survey (D'Andrea, Daniels & Heck, 1991) was specially designed for counselors; and Rooda's Cultural Fitness Survey measured cultural knowledge and attitudes only for specified ethnic groups (1993).

Data Collection

Permission to utilize facilities was obtained prior to subject recruitment, and was documented with approval letters granting research privileges. Verbal permission was obtained from ED managers before questionnaire distribution, which was completed during shift changes. Prior to distribution, a short introduction to the study was given by the researcher.

As part of the introduction, all participants were informed that answering the questionnaire was strictly voluntary, and that the information obtained would not be

used for purposes other than this study. In an effort to maintain confidentiality and anonymity, participants were requested not to sign the questionnaire.

Participants were reminded that at any time while filling out the questionnaire, they were free to withdraw from the study. Completed questionnaires were left in an envelope that was later collected by the researcher.

A book on cultural nursing was offered to each participating facility in appreciation for the staff's time and effort in completing the questionnaire, and to reiterate the importance of cultural considerations in nursing. The book was given to the ED manager, for ED use at their discretion.

Statistical Analysis

The following information about the sample was collected and descriptively analyzed as follows: age, gender, type of nursing practiced (military or civilian), nursing education, and amount of ED nursing experience. Cultural characteristics of ethnicity, cultural education, and minority status (length of time lived as a minority, if applicable), were also assessed.

Differences between CCQ scores and gender, ethnicity, type of nursing being practiced, and those with and without minority exposure were examined. Differences in age between

military and civilian nurses was examined. Given that this research was exploratory in nature, multiple t-tests were used, even though this approach to statistical analysis may have increased the likelihood of finding false significance.

Chapter Four

Results

The sample is described in terms of age, gender, type of nursing practiced, nursing education, and amount of ED nursing experience (Table 2). Cultural characteristics of ethnicity, cultural education, and minority data are shown in (Table 3).

The average participant from this sample was between 36 and 45 years of age, female, Caucasian, practicing civilian nursing, and baccalaureate prepared. The average participant perceived the percentage of minority patients cared for between 21-30%, had "some" cultural content in nursing education, and had worked in the ED between 6 months and 2 years.

Minimal ethnic diversity was present in the sample, as two African-Americans completed the questionnaires, and all other participants (n=39) were Caucasian. No significant differences were found between CCQ scores and ethnic background.

The percentage of male nurses in this sample (n=12) was proportionately higher than the norm (ranges between 3% to 6%) among nurses. This study sample was 29% male and 71% female. The majority of the sample was practicing civilian nursing (76%), as opposed to military nursing (24%).

Table 2

General characteristics of survey participants

CHARACTERISTIC	n	% of sample
Age		
19-25	1	2.5
26-35	8	20
36-45	22	55
46-55	9	22.5
Total	*40	100
*1 participant declined to list age		
Gender		
Male	12	29.3
Female	29	70.7
Total	41	100
Type of nursing practiced		
Civilian	31	75.6
Military active duty	9	22
Military reserve	1	2.4
Total	41	100
Nursing education		
Diploma	1	2.5
Associate	10	25
Bachelor	27	67.5
Masters	2	5
Total	*40	100
*1 participant declined to list educational level		
Amount of ED nursing experience		
6 months or less	1	2.4
6 months+ to 2 years	15	36.6
2 years+ to 5 years	8	19.5
5 years+ to 8 years	4	9.8
8 years+ to 11 years	7	17.1
11 years +	6	14.6
Total	41	100.0

Table 3

Cultural characteristics of survey participants

CHARACTERISTIC	n	% of sample
Ethnicity		
African-American	2	4.9
Caucasian	39	95.1
Total	41	100
Cultural education		
A lot	5	12.2
Some	19	46.3
Very little	16	39.1
None	1	2.4
Total	41	100
Lived as a minority		
Yes	15	36.6
No	26	63.4
Total	41	100
Amount of time lived as minority (If "yes" to above)		
6 months or less	1	6.7
6 months+ to 2 years	4	26.7
2 years+ to 5 years	5	33.3
5 years+ to 8 years	2	13.3
8 years+ to 11 years	1	6.7
11 years +	2	13.3
Total	*15	100

*26 participants had not lived as minorities

CCQ scores from the total sample revealed a mean of 33.7, standard deviation of 3.3, and a range of 28-41 (possible scores were from 9 to 45). A Cronbach's alpha of .58 was calculated on sample responses.

There were no significant differences in CCQ scores between ethnic groups (African-American M=37.6, Caucasian M=33.5, t=1.80, p=.08), or between participants with (M=33.8) and without minority experience (M=33.7, t=.09, p=.93)

Significant differences were not found between CCQ scores and the following variables: nursing education levels ($F(3,36) = .43$, p=.73); perceived percent of minority patients cared for ($F(5,35) = 1.11$, p=.37); and amount of cultural education ($F(3,37) = .35$, p=.79).

Significant difference in CCQ scores were found between males (M=32.2) and females (M=34.3, t=-2.0, p=.05), and between civilian (M=34.3) and military nurses (M=31.9, t=2.08, p=.04). Significant differences in age were noted between military (M=36.4) and civilian types of nursing (M=41.4, t=2.31, p=.03).

Chapter 5

Discussion of Findings

Significant differences in age were found between civilian and military nurses. Military nurses were younger (M=36.4) than their civilian counterparts (M=41.4). Perhaps the age difference and high proportionality of male to female nurses in the military has some effect on military nurse scores on the CCQ. Further research would need to be done in this area before definitive conclusions could be drawn.

Amount of cultural exposure did not appear to affect CCQ scores. There were no significant differences in CCQ scores between those who had lived as minorities and those who had not. This was surprising to the researcher, who speculated that perhaps increased cultural exposure would result in higher CCQ scores. Living as a minority can result in positive or negative attitudes, depending on the type of encounter experienced.

Amount of cultural education did not appear to significantly affect CCQ scores. Most participants had received between "very little" (n=16) to "some" (n=19) cultural diversity education, although a few nurses (n=5) reported having received "a lot". This method of measuring cultural education was general, but sufficient for getting

an idea of whether or not nurses had received cultural education in their basic nursing preparation.

Reliability and Validity

A Cronbach's alpha of .58 was calculated on the sample's responses to the CCQ. Two of the questions, numbers 1 and 4, had negative correlations with the total.

The striking finding about this is that both of these were reverse-scored items, and the only other reverse-scored item had the next lowest correlation among all other questions. By dropping item 1, a coefficient alpha of .69 could be obtained, which is extremely close to the researcher's goal of .70. If items 1 and 4 were dropped, the Cronbach's alpha would be .76, and if all reverse-coded items were deleted, an alpha of .80 would result.

The validity of the CCQ results depends upon frank and honest responses of survey participants. Although subjects were assured anonymity, there is no way to know with certainty that they provided candid, rather than socially-acceptable responses. Predictive and construct validity will be examined in future research.

Implications for Emergency Nursing Practice

Patient perceptions of care are often related to the attitude of health care providers. Nurse attitudes can be quite influential, especially in the ED, where people of

many different ethnic backgrounds are seen, and where understanding immediate needs is of utmost importance.

Although this study did not show differences in attitudes of nurses related to their cultural exposure, the sample size was quite small (N=41). Perhaps this factor contributes to the lack of significance.

Males scored 2.15 points lower than females on the CCQ. This item is of interest, especially since most of the males surveyed (67%) were working in a military facility, and the military facility scored significantly lower than the civilian facilities. Since military nurses were younger than civilian nurses in the sample, it is possible that younger nurses perceive patients from diverse ethnic backgrounds differently than older nurses. There may also be a difference in the way male and female nurses deal with cultural differences. However, further research is needed to draw substantial conclusions.

Since scores obtained from the CCQ were on the high end of the scale (between 28-41) with a much wider span available (range 9-45), it is possible that respondents answered with socially desirable answers, rather than how they truly would react. This is not unexpected, as the questionnaire dealt with sensitive and personal questions,

but drawing definite conclusions from these scores would be premature.

Scope and Limitations

The sample in this study was limited to RNs currently working in either military or civilian EDs in a south central area of the U.S. Results cannot be generalized to other hospital units or geographical areas due to differences in cultures and populations of these locations, and because the sample was not randomized. Multiple t-tests were used, which may have increased the chance of finding false significance.

Recommendations for Study

This study examined attitudes of ED nurses toward caring for patients of diverse ethnicity. It would be interesting to see how these attitudes compare with those in other care settings, such as intensive care units, and also in different geographical locations. Perhaps trends could be found which would help explain and predict nurse attitudes in specific clinical and geographic areas.

A larger sample size is necessary to draw definitive conclusions among nurse attitudes and cultural exposure. Research into factors that contribute to nurse attitudes would be helpful in better understanding both positive and

negative attitudes, as would looking at the effects of current attitudes upon ethnically diverse patients.

Another pertinent area of investigation would be contributing factors that resulted in male nurses and military nurses receiving low scores on the CCQ. It would be interesting to research whether or not similar results occurred in replication studies in a variety of geographic and practice areas. Furthermore, research into outcomes is needed to examine what effect current attitudes have on the quality of care given to patients from various cultural backgrounds in EDs around the country.

Conclusion

As America becomes a home for immigrants from around the world, it is imperative that ED nurses, as well as other health care professionals, take an introspective look at their personal attitudes toward caring for people with backgrounds different from their own. A myriad of influences affect nurse attitudes, but despite these, all patients, especially minorities, immigrants, and those unfamiliar with our health care system, deserve the highest possible quality of health care available.

Appendix A

Institutional Review Board Approval

UNIVERSITY OF KENTUCKY

Research and Graduate Studies

Research Subjects Office
315 Kinkead Hall
Lexington, KY 40506-0057
www.rgs.uky.edu/rso/homepg.htm
Nonmedical IRB: (606) 323-2446
Medical IRB: (606) 257-3138
IACUC: (606) 257-2934

Initial Review	Approval Ends	Project Ends	IRB Number
	August 24, 1998	November 15, 1997	97-00261

TO: Catherine A. Medland, RN
Nursing
617 Baldwin Ave
Lexington, KY 40502

FROM: Chairperson/Vice Chairperson
Medical Institutional Review Board (IRB)

SUBJECT: Approval of Protocol Number 97-00261

DATE: August 26, 1997

On August 25, 1997, the Medical Institutional Review Board approved your protocol entitled:

Analysis of Emergency Nurse Attitudes Toward Caring for Ethnically Diverse Patients

This approval extends to any consent/assent document unless the IRB has waived the requirement for documentation of informed consent.

Approval is effective from August 25, 1997 until August 24, 1998. If applicable, attached is the IRB approved consent/assent document(s) to be used when enrolling subjects. [Note, subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.] Prior to the end of this period, you will be sent a Continuation Review Report Form which must be completed and returned to the Research Subjects Office so that the protocol can be reviewed and approved for the next period.

In implementing the research activities, you are responsible for complying with IRB decisions, conditions and requirements. The research procedures should be implemented as approved in the IRB protocol.

Attached for your review is a booklet describing investigator responsibilities after IRB approval has been obtained. Please read the information carefully and retain a copy for your files. If you have questions or need additional information, contact the Research Subjects Office at 257-8315 (Medical) and 323-2446 (Nonmedical).

Linda Linville Ph.D. /lg

Chairperson/Vice Chairperson

An Equal Opportunity University

Appendix B

Data Collection Instrument

CULTURAL CARE QUESTIONNAIRE

I am interested in obtaining information on how Emergency Department nurses feel about caring for clients from diverse ethnic backgrounds.

To maintain confidentiality, please **do not sign questionnaire.**

Upon completion of the questionnaire, please place it in the designated area. Your time and input are greatly appreciated!

CULTURAL CARE QUESTIONNAIRE

SECTION I

Please answer the following questions by filling in the blank or circling the appropriate answer. All information given will remain confidential and will be used only for this study. Thanks for your time!

1. Age:_____

2. Sex: (a) Male
   (b) Female

3. Which category best describes your ethnic background?
   (a) African-American
   (b) American Indian or Alaska Native
   (c) Asian or Pacific Islander
   (d) Caucasian or White
   (e) Hispanic
   (f) Other (Please specify)_____

4. The type of nursing I am currently practicing is:
   (a) civilian
   (b) military active duty
   (c) military reserve

5. Nursing Education:
   (Highest degree completed)
   (a) Diploma
   (b) Associate
   (c) Bachelor
   (d) Masters
   (e) Doctorate

   Other degree(s) completed:
   Degree_____Major_____

6. How long have you worked as an RN in the Emergency Department?

   _____years and/or _____months

7. Based on your overall impression, what is the approximate percentage of patients you care for from non-dominant (minority) backgrounds?

(a) 0-10% (d) 31-40% (g) 61-70%
(b) 11-20% (e) 41-50% (h) greater than 70%
(c) 21-30% (f) 51-60%

8. To what degree did your basic nursing program provide meaningful content on cultural diversity as it relates to health care in general?

(a) a lot (c) very little
(b) some (d) none

9. Have you ever lived in an area where your ethnic group and/or culture was the minority? (Not including brief vacations)

(a) Yes
(b) No

10. If you answered "Yes" to number 9, approximately how long (in months and years) did you live as a minority?

_____years and/or _____months

SECTION II

Using the scale below, please answer the following questions honestly in accordance with your feelings. There are no right or wrong answers.

1	2	3	4	5
Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**

1. Patients from differing ethnic/cultural backgrounds should be treated the same when coming to the ED for care.	1	2	3	4	5
2. In general, I try to give care appropriate to the specific culture of the patient when caring for patients in the ED.	1	2	3	4	5

1	2	3	4	5
Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**

3. When performing life-saving measures, I can still adequately meet the cultural needs of most patients.	1	2	3	4	5
4. I feel ED patients should be treated according to what is culturally acceptable for the majority of patients.	1	2	3	4	5
5. Although it is difficult trying to accommodate cultural needs of patients in the ED, it can be done.	1	2	3	4	5
6. I have negative attitudes toward cultural backgrounds different from my own.	1	2	3	4	5
7. When caring for a client from an ethnic background different than my own, I try to learn from the patient.	1	2	3	4	5
8. I feel that obtaining cultural information in the ED is vital to good nursing care.	1	2	3	4	5
9. I attempt to incorporate culturally appropriate treatment methods into my nursing care.	1	2	3	4	5

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Vita

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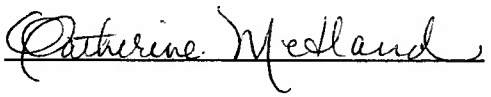
PII Redacted [redacted]



Education:

Date	Degree	Institution
1989	BSN	Idaho State University Pocatello, Idaho

Professional Experience:

Date	Title	Institution
8/96-12/97	MSN Student, RN	University of Kentucky Lexington, Kentucky
3/95-7/96	ED Red Cross Nurse (Volunteer)	Yokota Air Base Hospital
7/94-7/96	Flight Clinical Coordinator	374 Aeromedical Evacuation Squadron
12/93-7/96	Flight Nurse	374 Aeromedical Evacuation Squadron
4/92-11/93	Obstetrical Staff Nurse	Incirlic Air Base Hospital, Turkey
3/90-3/92	Obstetrical Staff Nurse	Homestead Air Base Hospital, Florida
9/90-3/91	Medical/Surgical Staff Nurse	King Fahd Air Base Saudi Arabia
9/89-3/90	Obstetrical Nurse Intern	Wright-Patterson Medical Center, Dayton, Ohio
8/89-9/89	Surgical Staff Nurse	Bannock Regional Medical Center, Pocatello, Idaho

Professional Honors

Sigma Theta Tau International - Theta Upsilon Chapter
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